Unacceptable Jessica
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No more clinical trials needed

Because: Safe and Effective. Foreverrrrrrrrrururrrururururr

Jessica Rose
Jun 28

239 25

First of all, read this please.

> **Unacceptable Jessica**
>
> **When you hear BNT162c(2), run, don't walk, RUN away.**
>
> Please head to the document entitled: "INVESTIGATOR'S BROCHURE BNT162/PF-07302048" dated August 12, 2020. About half a year ago, I suppose, I virtually sat across from a Canadian researcher who was developing a new technology called self-amplifying RNA (saRNA). If you want, you can watch that interview...
>
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> 10 days ago · 422 likes · 86 comments · Jessica Rose

Now please go to this document entitled: "FDA Briefing Document Vaccines and Related Biological Products Advisory Committee Meeting June 28, 2022 SARS-CoV-2 strain composition of COVID-19 vaccines". This is the meeting that these same financially-conflicted people will vote on to decide for the entire world that clinical trials are pish tosh - no need for them anymore.

But this is why, besides the obvious reasons, you should really care. They have started trialing the self-amplifying version of these modified RNA gene therapy products. Once they 'make it through' (they'll really need to fudge those adverse event counts), there will be no further requirements to test for safety or efficacy. That means, that no matter how bad these things continue to, or begin to, mess up people, there will be no way to ascribe these damages to the products.

Please read it here.

Toby Rogers wrote a great summary here in the Defender.

The document, to me, seeing as how it will literally affect every single human being on the planet, is pathetic. I can confirm from Toby's report that there are a lamentable number of references (19), and my role here will be to go through each one and quote the conclusions of the paper/document referenced to see if the backbone of this report is credible. Let's see how I do.

Reference #1: Andrews N, Stowe J, Kirsebom F, et al. NEJM 2022. DOI: 10.1056/NEJMoa2119451

First of all what citing structure is this? APA? MLA? NLM? The proper way to cite this published paper is like this.[1] This looks like the way I used to cite papers before I knew how to do it. The people who wrote this document should *know* this.

The conclusion of this paper is as follows:

> **Conclusions:** Primary immunization with two doses of ChAdOx1 nCoV-19 or BNT162b2 vaccine provided limited protection against symptomatic disease caused by the omicron variant. A BNT162b2 or mRNA-1273 booster after either the ChAdOx1 nCoV-19 or BNT162b2 primary course substantially increased protection, but that protection waned over time. (Funded by the U.K. Health Security Agency.).

Without long-term data, the only conclusion from this paper would be that the COVID-19 products are ineffective overall. It is ***not*** recommended to mix these products[2] by the WHO's own chief scientist Soumya Swaminathan, so why is this being used as a strange rescue method in this study?

Reference #2: Arbel R, Sergienko R, Friger M, et al: BNT162b2 vaccine booster and mortality due to COVID-19. N Engl J Med 2021; 385:2413-2420.DOI: 10.1056/NEJMoa2115624[3]

The problem that I have with this paper is that they studied 2 groups of people: 'boosted' and 'non-boosted' people. But, here's the clincher. By their definition, "Up to 7 days after receiving the booster, participants were still included in the nonbooster group." What this definitively means is that any and all of the people counted in the non-booster death group (of which there were 137), who were injected with the 3rd shot, could have actually belonged to the booster death group. Here's a visual:

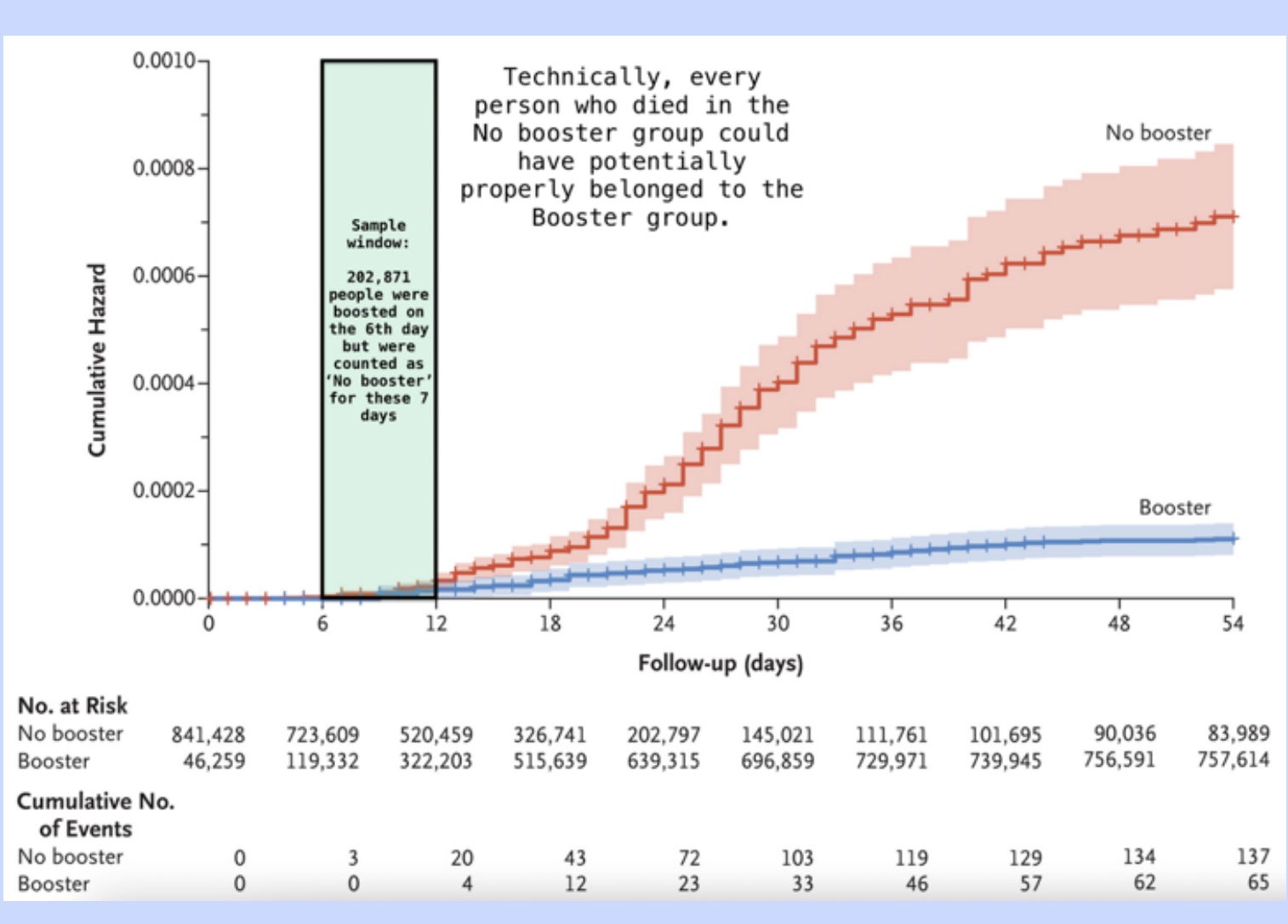
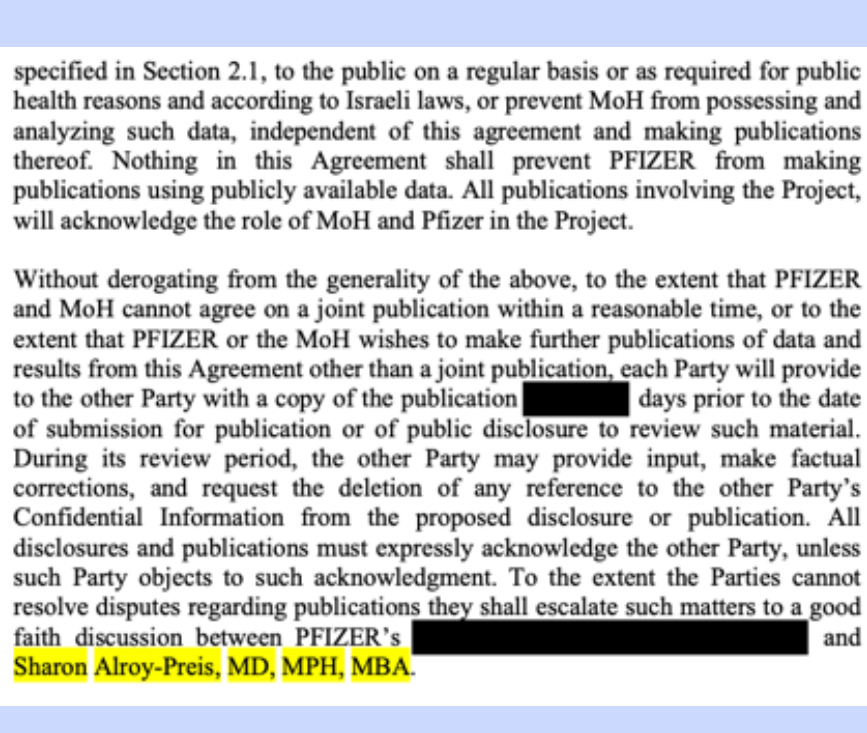


Figure 1: Figure 2 extracted and enhanced from N Engl J Med 2021 Dec 23;385(26):2413-2420. doi: 10.1056/NEJMoa2115624.Epub 2021 Dec 8.

It is unlikely that all of the people who died were all 'Booster' clad, but, unless I misunderstand, this is technically possible according to their definition.

Reference #3: Bar-On YM, Goldberg Y, Mandel M, et al. Protection by 4th dose of BNT162b2 against Omicron in Israel. medRxiv, February 1, 2022; doi: https://doi.org/10.1101/2022.02.01.22270232. Preprint[4]

I have 2 things to note: it's not peer-reviewed yet and Sharon-Alroy Preis is seriously conflicted, in my opinion, and they declare no conflicts. She works for the Israeli Ministry of Health and although has 'officially' no COIs, there is no sign of the proof of that claim as requested by FOIA.[5] She signed on the original agreement with Pfizer as a mediator with regard to publications.[6] And the hospital she works at got a big gift from Pfizer in the way of grant money, according to the article referenced here.[7]



specified in Section 2.1, to the public on a regular basis or as required for public health reasons and according to Israeli laws, or prevent MoH from possessing and analyzing such data, independent of this agreement and making publications thereof. Nothing in this Agreement shall prevent PFIZER from making publications using publicly available data. All publications involving the Project, will acknowledge the role of MoH and Pfizer in the Project.

Without derogating from the generality of the above, to the extent that PFIZER and MoH cannot agree on a joint publication within a reasonable time, or to the extent that PFIZER or the MoH wishes to make further publications of data and results from this Agreement other than a joint publication, each Party will provide to the other Party with a copy of the publication [redacted] days prior to the date of submission for publication or of public disclosure to review such material. During its review period, the other Party may provide input, make factual corrections, and request the deletion of any reference to the other Party's Confidential Information from the proposed disclosure or publication. All disclosures and publications must expressly acknowledge the other Party, unless such Party objects to such acknowledgement. To the extent the Parties cannot resolve disputes regarding publications they shall escalate such matters to a good faith discussion between PFIZER's [redacted] and Sharon Alroy-Preis, MD, MPH, MBA.

Figure 2: REAL-WORLD EPIDEMIOLOGICAL EVIDENCE COLLABORATION AGREEMENT. Page redacted. Under Section 9. Publications and Publicity.

The bottom line for me is, if I see her name, I get very suspicious. Let me put it this way, a person can put a sign on their gate that they own a dog that is not aggressive but this has no true bearing on whether or not the dog is aggressive. The 'but it was written on the sign' thing doesn't really fly with me. I'd rather align with how things *are*, not how things *look*. She and her colleagues are promoting 4rth shots in this paper.

> **CONCLUSIONS** Rates of confirmed Covid-19 and severe illness were lower following a fourth dose compared to only three doses.

Reference #4: Chemaitelly H, Hussein H, Ayoub H, et al. Duration of mRNA vaccine protection against SARSCoV-2 Omicron BA.1 and BA.2 subvariants in Qatar. medRxiv 2022.03.13.22272308; doi: https://doi.org/10.1101/2022.03.13.22272308 Preprint[8]

This article is now published in Nature Communications. It is more of the same nonsense about 'boosting' to get 'back to' bloody 50% efficacy which the **Limit of Efficacy** according to the FDA for maintaining an EUA.[9]

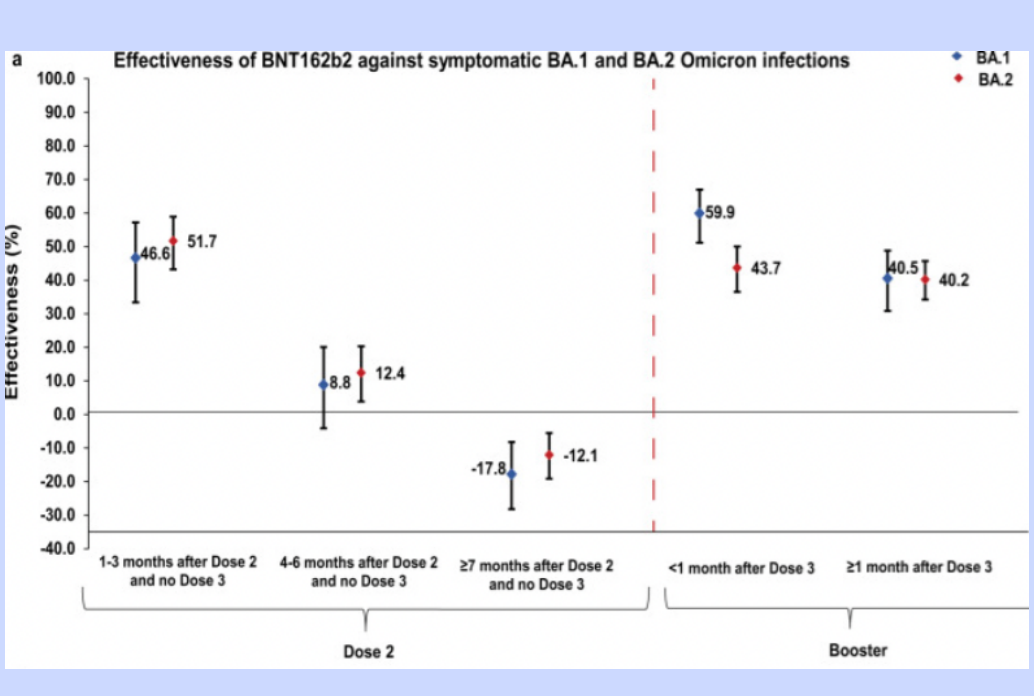


Figure 3: Fig. 3. Effectiveness of [BNT162b2 vaccine] against symptomatic SARS-CoV-2 BA.1 and BA.2 Omicron infections.Data are presented as effectiveness point estimates. Error bars indicate the corresponding 95% confidence intervals. Published online 2022 Jun 2. doi: 10.1038/s41467-022-30895-3.

I don't know if it's just me, but why is it becoming normal to keep injecting people repeatedly to get crappy results. This chart shows that the effectiveness is <52% to begin with and gets increasingly worse with time. 'Boosting' is eventually, going to end up with the same unhappy ending, but you see here's the thing: **no one is asking what this is doing to the immune system and no one acknowledges adverse event occurrences.**

They conclude:

> **mRNA vaccines provide comparable, moderate, and short-lived protection against symptomatic BA.1 and BA.2 Omicron infections, but strong and durable protection against COVID-19 hospitalization and death.**

Who gives damn is this 'data' shows reduction in death from COVID-19 if more people are dying from repeated injection/exposure to your products! Do *that* study.

Reference #5: Ferdinands JM, Rao S, Dixon BE, et al. Waning 2-Dose and 3-Dose Effectiveness of mRNA Vaccines Against COVID-19–Associated Emergency Department and Urgent Care Encounters and Hospitalizations Among Adults During Periods of Delta and Omicron Variant Predominance — VISION Network, 10 States, August 2021–January 2022. MMWR Morb Mortal Wkly Rep 2022;71:255–263. DOI: https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.htm[10]

This is one of the many Morbidity and Mortality Weekly Report (MMWR) reports provided by the CDC. In other words, in my opinion, they are conflicted. I don't correct my own homework. Do you?

> All eligible persons should remain up to date with recommended COVID-19 vaccinations to best protect against COVID-19–associated hospitalizations and ED/UC visits.

They're pushing for more injections. No new results. They claim that because of variants and hospitalization rate increases a few months after each dose that this is evidence that we should keep dosing people.

Reference #6: Gazit S, Saciuk Y, Perez G, et al. Relative Effectiveness of Four Doses Compared to Three Dose of the BNT162b2 Vaccine in Israel. medRxiv 2022.03.24.22272835; doi: https://doi.org/10.1101/2022.03.24.22272835. Preprint[11]

Another sign that this document was not made by seasoned professionals. They reference the preprint that you can find here, uploaded on Mar 24, 2022, but the published article has been accepted and is up on Pubmed published on May 24, 2022; accepted on May 5, 2022.

This paper is more of the same. It's nice that these studies using different study groups agree, but they agree on a pointless and potentially dangerous conclusion. Just keep injecting yourself - you'll be fine. Not protected from COVID-19, but it might keep you from dying from COVID-19. They claim that fewer people died from 'severe covid-19 disease' in in the fourth shot group, but again, what data shenanigans were played? Is this another case of mis-defining?

Oh and by the way, we can't promise the repeated injections won't kill you. Just so that you know.

> **Conclusions:** A fourth dose of the BNT162b2 vaccine appears to have provided additional protection against both SARS-CoV-2 infection and severe covid-19 disease relative to three vaccine doses. However, relative effectiveness of the fourth dose against infection appears to wane sooner than that of the third dose.

Reference #7: Hachmann NP, Miller J, Collier AY et al. Neutralization Escape by the SARS-CoV-2 Omicron Variants BA.2.12.1 and BA.4/BA.5 medRxiv 2022. DOI: https://doi.org/10.1101/2022.05.16.22275151. Preprint[12]

This pre-print (and also this Letter to the Editor), is about immune escape induced by mass vaccination with non-sterilizing products. Do I really need to say anything else here?

> These findings provide immunologic context for the current surges caused by the BA.2.12.1, BA.4, and BA.5 subvariants in populations with high frequencies of vaccination and BA.1 or BA.2 infection.

Reference #8: Iketani S, Liu L, Guo Y et al. Antibody evasion properties of SARS-CoV-2 Omicron sublineages. Nature 2022. DOI: 10.1038/s41586-022-04594-4[13]

This paper is also about immune escape in the context of mass vaccination and they report that the variants "threaten the efficacies of current vaccines." They also diss monoclonal antibody therapy "[our findings show] that no authorized monoclonal antibody therapy could adequately cover all sublineages of the Omicron variant". I have an idea: STOP INJECTING PEOPLE AND THE VARIANTS WON'T EMERGE.

Reference #9: Korves C, Izurieta HS, Smith J, Zwain GM, Powell EI, Balajee A, Ryder K, Young-Xu Y. Relative effectiveness of booster vs. 2-dose mRNA Covid-19 vaccination in the Veterans Health Administration: Self-controlled risk interval analysis. medRxiv 2022.03.17.22272555; Preprint. DOI: https://doi.org/10.1101/2022.03.17.22272555[14]

Also in pre-print with a in-press corrected proof on the way in the journal *Vaccine*.

> **Conclusions** Booster vaccination was more effective relative to a 2-dose primary series, the relative effectiveness was consistent across age groups and was higher during the Delta predominant period than during the Omicron period.

More booster promotion. Next.

Reference #10: Lusvarghi S, Pollett SD, Neerukonda SN et al. SARS-CoV-2 BA.1 variant is neutralized by vaccine booster-elicited serum but evades most convalescent serum and therapeutic antibodies. Sci Transl Med 2022. DOI: 10.1126/scitranslmed.abn8543[15]

> These findings underscore the potential benefit of mRNA vaccine boosters for protection against Omicron and the need for rapid development of antibody therapeutics that maintain potency against emerging variants.

Well this is a change. They are promoting boosters again. But wait, they are also promoting therapeutic antibodies? "Five monoclonal antibodies retained measurable neutralization activity against Omicron with a varying degree of potency." Wow! But I thought we hated MAs?

Reference #11: Mannar D, James W Saville JW, Zhu X et al. SARS-CoV-2 Omicron variant: Antibody evasion and cryo-EM structure of spike protein-ACE2 complex. Science 2022. DOI: 10.1126/science.abn7760[16]

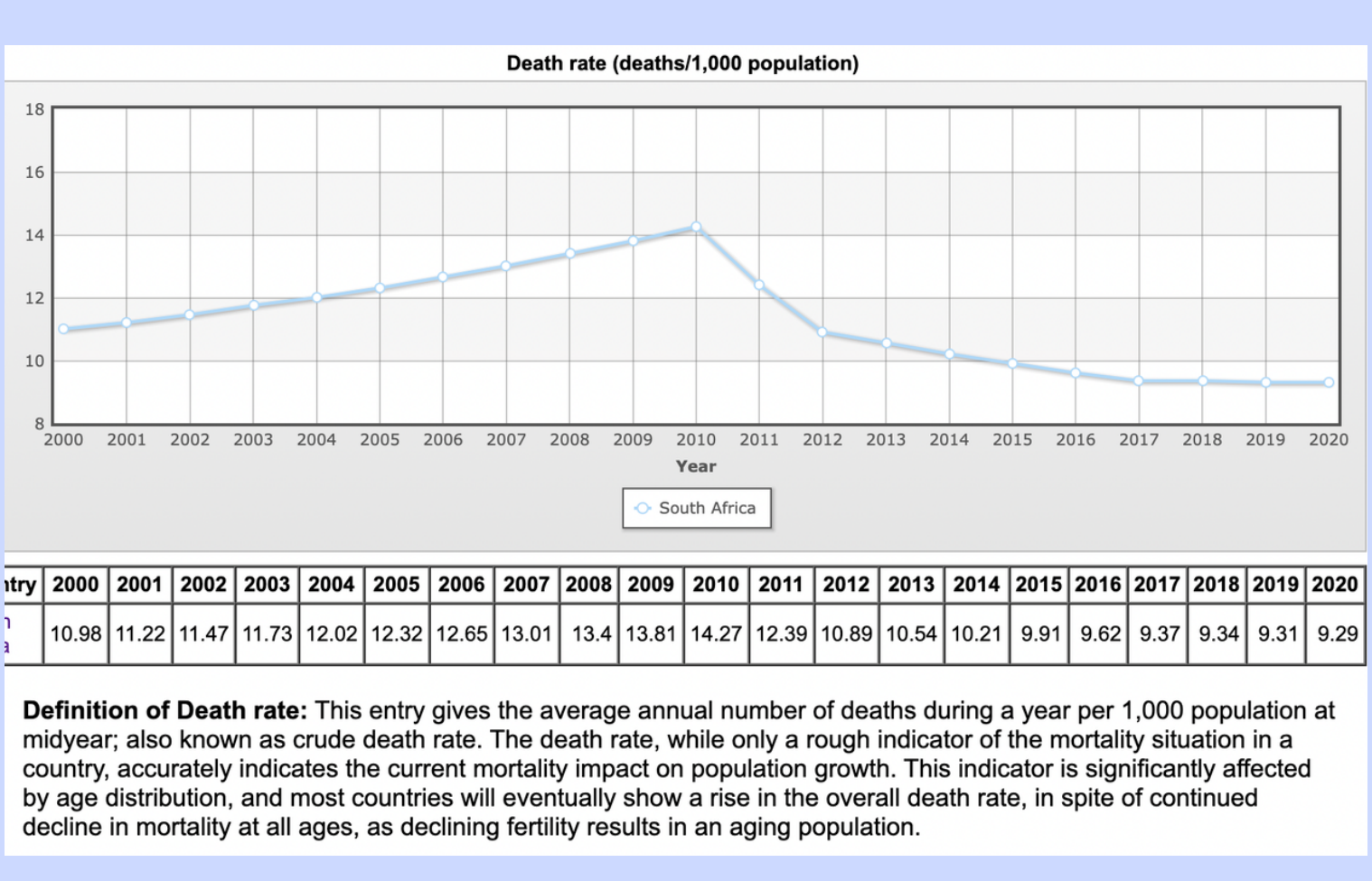
Well, well, well! Cryo structures! Finally something interesting. So these guys used cryo-EM to visualize the binding site between the binding residues of the Omicron variant and ACE-2 and show that specific residues associated with salt bridges and hydrogen bonds make Omicron just as bind-eriffic as Delta! Hence why it's such a popular guy: it loves to hug and is good at it! Ok. So?

Reference #12: Pulliam JRC, van Schalkwyk C, Govender N et al. Increased risk of SARS-CoV-2 reinfection associated with emergence of Omicron in South Africa. Science 2022. DOI: 10.1126/science.abn4947[17]

This paper is published in Science so it must be good. It's pretty good! They use modeling and another analytical approach (Approach 1: Catalytic model assuming a constant reinfection hazard coefficient and Approach 2: Estimation of time-varying infection and reinfection hazards) to show that Omicron is different from the other variants in that people are pre-disposed to get it if they had been previously introduced to other variants.

> We find evidence of a substantial increase in the risk of reinfection that is temporally consistent with the timing of the emergence of the Omicron variant in South Africa, suggesting that Omicron's selection advantage is at least partially driven by an increased ability to infect previously infected individuals.

Ok. That's pretty interesting. But again. Perspective. The death rate in South Africa as of 2020 was on a decline at 9/1,000 people.

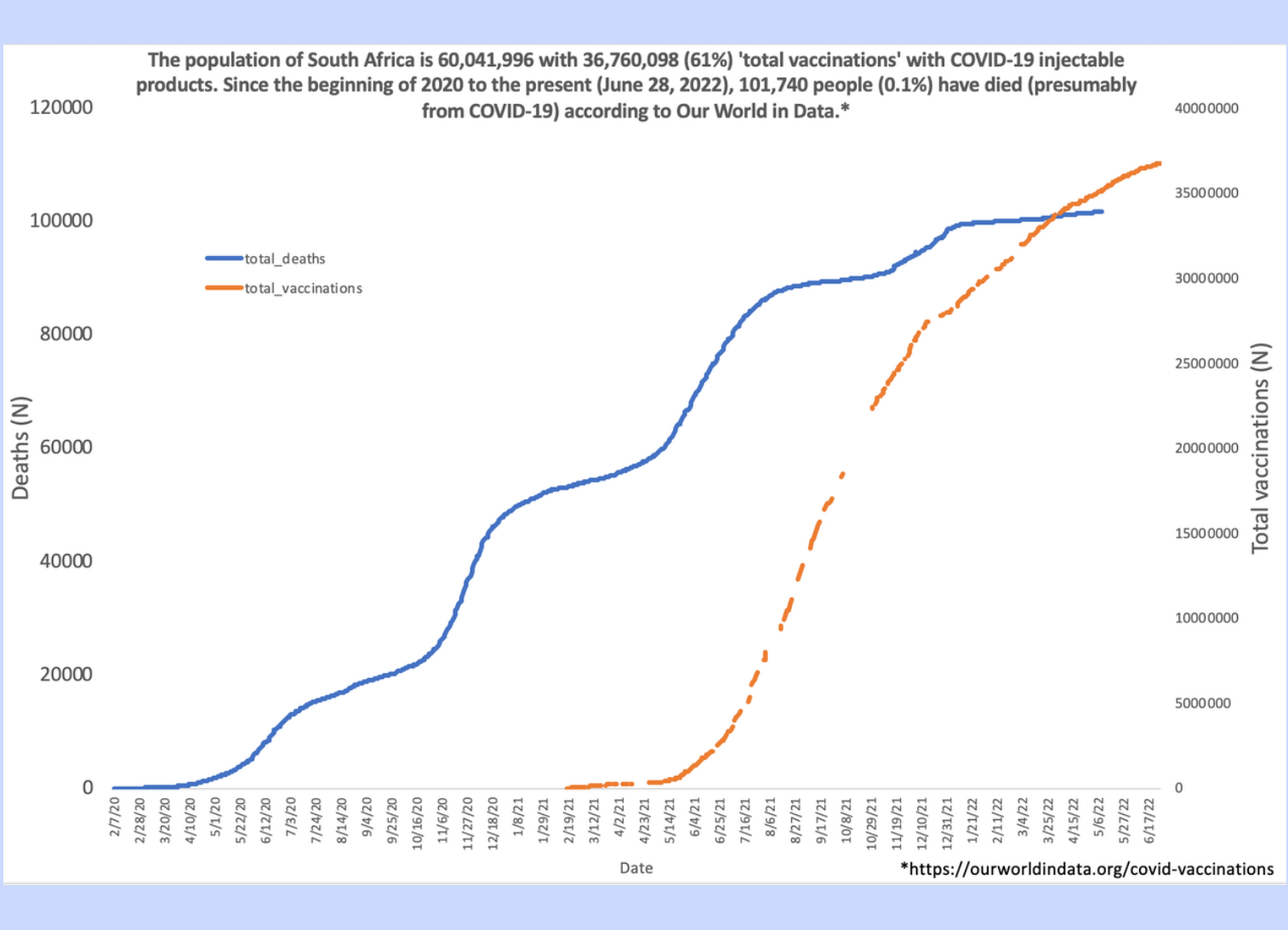


try	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
	10.98	11.22	11.47	11.73	12.02	12.32	12.65	13.01	13.4	13.81	14.27	12.39	10.89	10.54	10.21	9.91	9.62	9.37	9.34	9.31	9.29

Definition of Death rate: This entry gives the average annual number of deaths during a year per 1,000 population at midyear; also known as crude death rate. The death rate, while only a rough indicator of the mortality situation in a country, accurately indicates the current mortality impact on population growth. This indicator is significantly affected by age distribution, and most countries will eventually show a rise in the overall death rate, in spite of continued decline in mortality at all ages, as declining fertility results in an aging population.

https://www.indexmundi.com/g/g.aspx?v=26&c=ca&l=en

According to Our World in Data, 101,740 South Africans have died in the context of COVID-19 from the beginning of the pandemic (dated here as 2/7/20). The number of deaths shown below have tapered off since the beginning of this year.



And not to be insensitive, but more than twice as many children (~260,000) under 5 died of starvation in East Africa in 2021 alone.[18]

All in all, nice paper. But susceptibility to Omicron could be due to the shots. Just saying.

Reference #13: Qu P, Faraone J, Evans JP et al. Neutralization of the SARS-CoV-2 Omicron BA.4/5 and BA.2.12.1 Subvariants. N Engl J Med 2022. DOI: 10.1056/NEJMc2206725[19]

> In this study, we characterized infection-induced immunity and vaccine-induced immunity against newly emerged omicron subvariants. Booster vaccination provided sufficient neutralizing-antibody titers against the BA.4/5 and BA.2.12.1 subvariants, albeit to a lower extent than against BA.1 and BA.2. These findings underscore the importance of booster vaccination for protection against emerging variants.

Ok, maybe I getting tired, but isn't this the same paper as reference #7? They even have almost the same title. "Neutralization Escape by SARS-CoV-2 Omicron Subvariants BA.2.12.1, BA.4, and BA.5". I leave this one to you guys.

Reference #14: Richardson SI, Madzorera VS, Spencer H et al. SARS-CoV-2 Omicron triggers cross-reactive neutralization and Fc effector functions in previously vaccinated, but not unvaccinated, individuals. Cell Host Microbe 2022. DOI: 10.1016/j.chom.2022.03.029[20]

> Although Omicron-based immunogens might be adequate boosters, they are unlikely to be superior to existing vaccines for priming in SARS-CoV-2-naive individuals.

So here they're saying that even though the people who've already got the shots need to keep getting shots, the poor people who haven't gotten any shots, need shots.

Reference #15: Stowe J, Andrews N, Kirsebom F et al. Effectiveness of COVID-19 vaccines against Omicron and Delta hospitalisation: test negative case-control study. Preprint. https://khub.net/documents/135939561/430986542/Effectiveness+of+COVID19+vaccines+against+Omicron+and+Delta+hospitalisation+-+test+negative+casecontrol+study.pdf/d0e803c0-3dd2-0c1b-03b8-0a12fd211980[21]

Ok, I've been keeping my mouth shut about citation styles up until now, but come on. What the hell is that?

This is a not really a pre-print even though they refer to it that way: it has not been accepted as a pre-print and uploaded to a pre-print server. Although it looks like they did a lot of work here and it comes down to this reduction in hospitalization (here by using only the 'best' ICD-10 codes indicative of an actual emergency) thing in the context of shots and Omicron.

> In conclusion, we found high levels of booster VE against hospitalisation with the Omicron variant, in particular among older adults who are at greatest risk, and against more severe end points. Nevertheless, there is evidence of limited waning from 3 to 4 months after a booster dose. Care should be taken in comparison of VE against hospitalisation across different studies due to the impact of using different outcome definitions.

Eh. Same same.

Reference #16: Taylor CA, Whitaker M, Anglin O, et al. COVID-19–Associated Hospitalizations Among Adults During SARS-CoV-2 Delta and Omicron Variant Predominance, by Race/Ethnicity and Vaccination Status — COVID-NET, 14 States, July 2021–January 2022. MMWR Morb Mortal Wkly Rep 2022;71:466–473. DOI: https://www.cdc.gov/mmwr/volumes/71/wr/mm7112e2.htm[22]

Another homework check by the people do did the homework.

> In January 2022, unvaccinated adults and those vaccinated with a primary series, but no booster or additional dose, were 12 and three times as likely to be hospitalized, respectively, as were adults who received booster or additional doses. Hospitalization rates among non-Hispanic Black adults increased more than rates in other racial/ethnic groups.

This is just not correct, in my opinion. I dare say it's the old trick of mis-defining. Next.

Reference #17: Tenforde MW, Patel MM, Gaglani M, et al. Effectiveness of a Third Dose of Pfizer-BioNTech and Moderna Vaccines in Preventing COVID-19 Hospitalization Among Immunocompetent and Immunocompromised Adults — United States, August–December 2021. MMWR Morb Mortal Wkly Rep 2022; 71:118–124. DOI: https://www.cdc.gov/mmwr/volumes/71/wr/mm7104a2.htm[23]

And another. Here they claim that we all need more shots and that they're also great for people who are immunocompromised. I question this.

> In a study of hospitalized adults, compared with receipt of 2 mRNA COVID-19 vaccine doses, receipt of a third dose increased vaccine effectiveness against hospitalization among adults without and with immunocompromising conditions, from 82% to 97% and from 69% to 88%, respectively.

Reference #18: Tseng HF, Ackerson BK, Luo Y, et al. Accepted, Nature Medicine. Effectiveness of mRNA1273 against SARS-CoV-2 Omicron and Delta variants. Nature Medicine, 2022. https://doi.org/10.1038/s41591-022-01753-y[24]

Nature Medicine. Hoowaeeee… Let's dig in even though this is my 18th article read - in ONE SITTING. Whoops! I spoke too soon. I'll just leave this here. And no, it's not a joke.

> ## Conflict of interest statement
>
> All authors have completed the International Committee of Medical Journal Editors uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare the following: H.F.T., B.K.A., Y.L., L.S.S., Y.T., J.E.T., A.F., J.H.K., G.S.L., S.K.C., H.S.T., M.A. and L.Q. are employees of **Kaiser Permanente Southern California**, which has been **contracted by Moderna, Inc.** to conduct this study. K.J.B. is an adjunct investigator at Kaiser Permanente Southern California. **C.A.T. is an employee of and a shareholder in Moderna, Inc.** H.F.T. received funding from GlaxoSmithKline and Seqirus unrelated to this manuscript. **H.F.T. also served on advisory boards for Janssen and Pfizer. B.K.A. received funding from** GlaxoSmithKline, Dynavax, Seqirus, **Pfizer** and Genentech for work unrelated to this study and has served on advisory boards for GlaxoSmithKline. **Y.L. received funding from GlaxoSmithKline, Seqirus and Pfizer** unrelated to this manuscript. L.S.S. received funding from GlaxoSmithKline, Dynavax and Seqirus unrelated to this manuscript. Y.T. received funding from GlaxoSmithKline unrelated to this manuscript. K.J.B. received funding from GlaxoSmithKline, Dynavax, Pfizer, Gilead and Seqirus unrelated to this manuscript. J.E.T. received funding from Pfizer unrelated to this manuscript. A.F. received funding from Pfizer, GlaxoSmithKline and Gilead unrelated to this manuscript. J.H.K. received funding from GlaxoSmithKline unrelated to this manuscript. G.S.L. received funding from GlaxoSmithKline unrelated to this manuscript. S.K.C. received funding from Pfizer and the Pancreatic Cancer Action Network unrelated to this manuscript. H.S.T. received funding from GlaxoSmithKline, Pfizer, ALK and Wellcome unrelated to this manuscript. M.A. received funding from Pfizer unrelated to this manuscript. L.Q. received funding from GlaxoSmithKline and Dynavax unrelated to this manuscript.

But none of the money they took is related to this work. Ok.

And last but not least!

Reference #19: Zhou T, Wang L, Misasi J et al. Structural basis for potent antibody neutralization of SARSCoV-2 variants including B.1.1.529. Science 2022. DOI: 10.1126/science.abn8897[25]

This is almost exactly what they did in Reference #11. Same techniques. Looking for monoclonal antibodies that potently neutralize. they do claim to have found synergistic relationship between monoclonal antibodies. That's cool!

So there you have it folks. I hope I did a good enough job here. My summary:

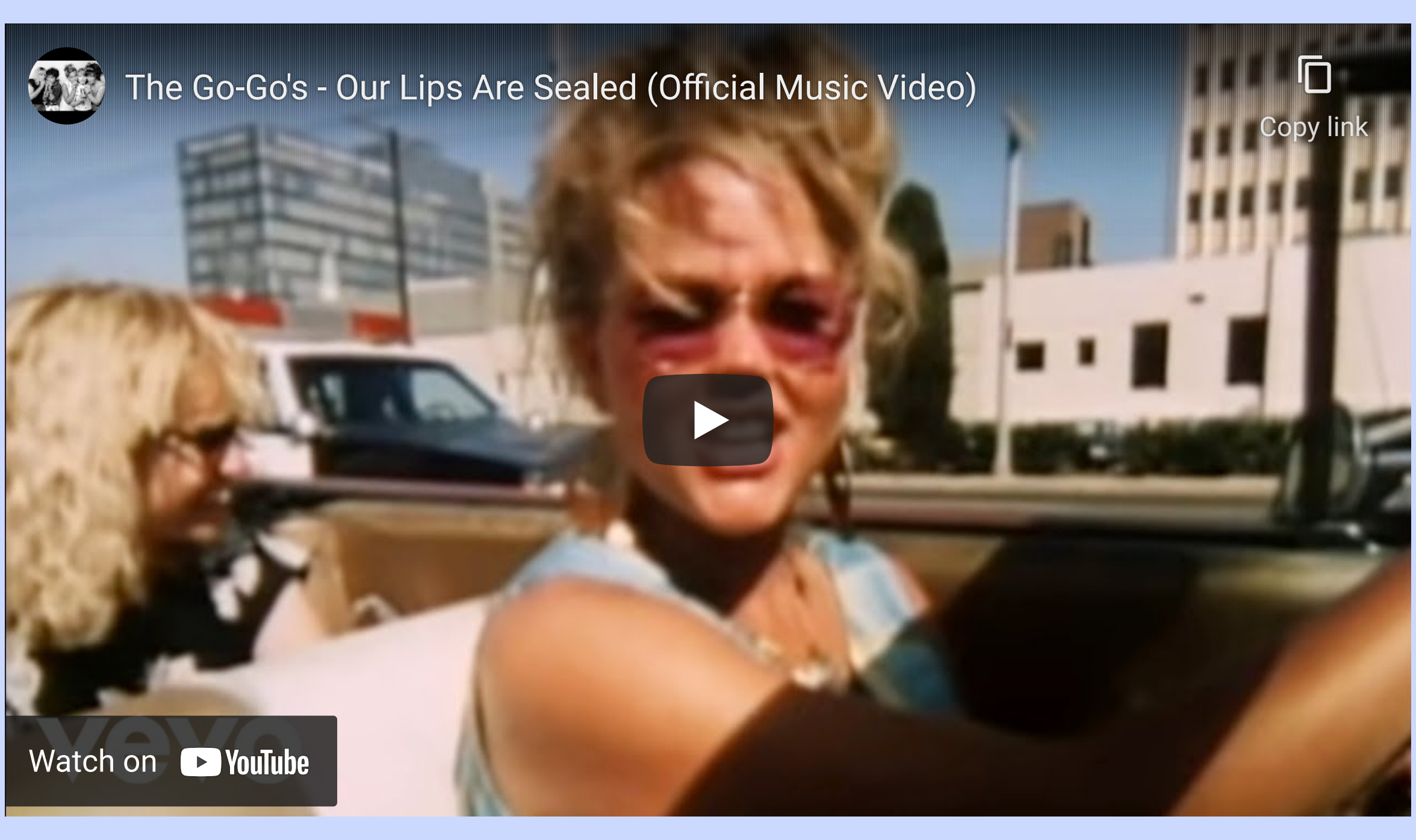
1. There are 2 sets of papers that appear to actually be the same report - perhaps with slight differences, but same conclusions. And normally in science, this is a good thing! But here, since they are simply providing questionable data supporting why we need to keep injecting ourselves, I am not so sure that needs reproduction.
2. There are 3 MMWR reports here used a references. Like I said, it's not 'illegal' to quote your own work, but it kind of makes me squeamish. How about you?
3. So that leaves 13 references, if you omit the one written by the incredibly

8. So that leaves 18 references, if you omit the one written by the incredibly conflicted authors, 6 are pre-prints (that includes the non-pre-print and the one in proof mode) and the remainder include conclusions based on mis-definitions, mixing products without having any long-term data relating to doing so, and many studies showing that Omicron is different from the other variants without a mention of where Omicron came from.

I am so sorry for the length of this piece. It's not like me, as you know. But I needed to try to be thorough.

My take home message is that if this is the document that allows the non-testing of any further variations of these COVID-19 experimental injectable products, including self-amplifying RNA, then as I said for the Pfizer and Moderna pre-VRBPAC meeting documents: IT'S NOT GOOD ENOUGH. NOT FOR ME.

Here's the anthem for the VRBPAC committee. And I love The Go-Gos.



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1 Andrews N, Stowe J, Kirsebom F, Toffa S, Rickeard T, Gallagher E, Gower C, Kall M, Groves N, O'Connell AM, Simons D, Blomquist PB, Zaidi A, Nash S, Iwani Binti Abdul Aziz N, Thelwall S, Dabrera G, Myers R, Amirthalingam G, Gharbia S, Barrett JC, Elson R, Ladhani SN, Ferguson N, Zambon M, Campbell CNJ, Brown K, Hopkins S, Chand M, Ramsay M, Lopez Bernal J. Covid-19 Vaccine Effectiveness against the Omicron (B.1.1.529) Variant. N Engl J Med. 2022 Apr 21;386(16):1532-1546. doi: 10.1056/NEJMoa2119451. Epub 2022 Mar 2. PMID: 35249272; PMCID: PMC8908811.

2 https://www.biospace.com/article/who-warns-against-mixing-and-matching-vaccines-and-more-covid-19-news/

3 Arbel R, Hammerman A, Sergienko R, Friger M, Peretz A, Netzer D, Yaron S. BNT162b2 Vaccine Booster and Mortality Due to Covid-19. N Engl J Med. 2021 Dec 23;385(26):2413-2420. doi: 10.1056/NEJMoa2115624. Epub 2021 Dec 8. PMID: 34879190; PMCID: PMC8728797.

4 Protection by 4th dose of BNT162b2 against Omicron in Israel. Yinon M. Bar-On, Yair Goldberg, Micha Mandel, Omri Bodenheimer, Ofra Amir, Laurence Freedman, Sharon Alroy-Preis, Nachman Ash, Amit Huppert, Ron Milo. medRxiv 2022.02.01.22270232; doi: https://doi.org/10.1101/2022.02.01.22270232

5 https://twitter.com/PECC_Israel/status/1541368263950622727?t=TFy9GVuarH3aM_qq_zntNw&s=19

6 REAL-WORLD EPIDEMIOLOGICAL EVIDENCE COLLABORATION AGREEMENT between MoH and Pfizer dated January 6, 2021. (I will give you pdf if you email me.)

7 https://rtmag.co.il/politics-and-economics/a-10,000-increase-in-donations-made-by-pfizer-to-health-organizations-in-israel

8 Chemaitelly H, Ayoub HH, AlMukdad S, Coyle P, Tang P, Yassine HM, Al-Khatib HA, Smatti MK, Hasan MR, Al-Kanaani Z, Al-Kuwari E, Jeremijenko A, Kaleeckal AH, Latif AN, Shaik RM, Abdul-Rahim HF, Nasrallah GK, Al-Kuwari MG, Butt AA, Al-Romaihi HE, Al-Thani MH, Al-Khal A, Bertollini R, Abu-Raddad LJ. Duration of mRNA vaccine protection against SARS-CoV-2 Omicron BA.1 and BA.2 subvariants in Qatar. Nat Commun. 2022 Jun 2;13(1):3082. doi: 10.1038/s41467-022-30895-3. PMID: 35654888; PMCID: PMC9163167.

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